SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Filing at a Glance

Company: Equitable Life & Casualty Insurance Company

Product Name: EquiChoice	SERFF Tr Num: ELCC-126026208	State: ArkansasLH
TOI: MS05I Individual Medicare Supplement - Standard Plans	SERFF Status: Closed	State Tr Num: 41494
Sub-TOI: MS05I.001 Plan A	Co Tr Num: A-OS-06 (AR)	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted	Reviewer(s): Stephanie Fowler
	Authors: Kathy Foster, Mark Banks, Jana Peterson	Disposition Date: 02/11/2009
	Date Submitted: 02/06/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 03/20/2009		Implementation Date:

State Filing Description:

General Information

Project Name: A-OS-06 (AR)	Status of Filing in Domicile: Not Filed
Project Number: A-OS-06 (AR)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/11/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/11/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Submitted for your review are the following Medicare Supplement forms for Equitable Life & Casualty Insurance Company:

Form Number	Form Type	Replaces Form

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

OLC 920 (07) AR Outline of Coverage OLC 920 (07) AR

A-OS-06 AR Application New Form

The outline of coverage form has been revised as described below and, upon approval, will replace the outline of coverage form filed with and approved by the Arkansas Insurance Department ("Department") on November 14, 2008. The application form is a new form and does not replace any previously approved forms.

The outline of coverage form will be used with our standard Medicare supplement plans under 920 (Rev) policy series and the 920 (Rev 07) policy series. The application form will be used with the 920 (Rev) policy series. These are individual products and will be marketed through licensed and appointed independent producers.

In our cover letter to the 920 (Rev 07) policy filing (State Tracking #40244), we stated that it was our intent to discontinue the availability of our standard plans B, C, D, E, F, High Deductible F (HDF), G and I plans under the 920 (Rev) form series, and that such action, when taken, would be done in accordance with state regulation. After further review of the marketplace and due to other factors, we have determined that such action is not warranted at this time.

To ensure that consumers are aware that these plans are available and to comply with Department Rule and Regulation 27, Section 17(C), we have revised the outline of coverage form to appropriately identify the plans that we offer and the rates associated with those plans.

The application form A-MSS-07 AR, approved by the Department on November 14, 2008 (State Tracking #40244), is specific to the standard plans A, H, J, high deductible J and L under the 920 (Rev 07) policy series. Due to the differences in underwriting between the plans, it was necessary to develop a new application form (A-OS-06 AR) that is specific to the plans B, C, D, E, F, HDF, G and I. At the time of solicitation, both the A-MSS-07 AR and A-OS-06 AR applications will be available to prospective insureds for review and completion.

Company and Contact

Filing Contact Information

Jana Peterson, Compliance Specialist Jana.Peterson@Equilife.com
3 Triad Center (877) 579-3782 [Phone]

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Salt Lake City, UT 84180 (801) 579-3781[FAX]

Filing Company Information

Equitable Life & Casualty Insurance Company	CoCode: 62952	State of Domicile: Utah
3 Triad Center	Group Code: -99	Company Type: Life and Health
Suite 200		
Salt Lake City, UT 84180	Group Name:	State ID Number:
(801) 579-3400 ext. [Phone]	FEIN Number: 87-0129771	

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	State Fee - $20 per form X 2 forms = $40
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Equitable Life & Casualty Insurance Company	$40.00	02/06/2009	25563457

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	02/11/2009	02/11/2009

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Disposition

Disposition Date: 02/11/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Approved	Yes

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELCC-126026208*	*State:*	*Arkansas*
Filing Company:	*Equitable Life & Casualty Insurance Company*	*State Tracking Number:*	*41494*
Company Tracking Number:	*A-OS-06 (AR)*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*EquiChoice*		
Project Name/Number:	*A-OS-06 (AR)/A-OS-06 (AR)*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Flesch Certification 02/06/2009

Bypass Reason: Not required

Comments:

Review Status:

Satisfied -Name: Application Approved 02/11/2009

Comments:

See General Information Filing Description for approval dates

Attachment:

A-OS-06_ar - app.pdf

Review Status:

Bypassed -Name: Health - Actuarial Justification 02/06/2009

Bypass Reason: No rates are being submitted

Comments:

Review Status:

Satisfied -Name: Outline of Coverage Approved 02/11/2009

Comments:

See General Information Filing Description for Approval dates.

Attachment:

Olc920-07-2008_ar.pdf

Equitable Life & Casualty Insurance Company
3 Triad Center, Salt Lake City, Utah 84180-1200
Application - Medicare Supplement Insurance

☐ New Business
☐ Coverage Change
☐ Add Spouse

Part I – Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____

Applicant Last Name

Given Name (First / Middle)

Birthdate (mm/dd/yyyy) Social Security Number

Height ft in Weight lbs Gender ☐ Male ☐ Female

Medicare ID Number:

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____

2nd Applicant Last Name

Given Name (First / Middle)

Birthdate (mm/dd/yyyy) Social Security Number

Height ft in Weight lbs Gender ☐ Male ☐ Female

Medicare ID Number:

Relationship to Applicant

Street Address

City State Zip

Best Time to Call (3 hour interval):_____ to _____

Weekend Calls: ☐ Yes ☐ No

Daytime Phone:

Evening Phone:

Cell Phone (optional):

E-Mail Address (optional):_____

Best Time to Call (3 hour interval):_____ to _____

Weekend Calls: ☐ Yes ☐ No

Daytime Phone:

Evening Phone:

Cell Phone (optional):

E-Mail Address (optional):_____

1

Part II - Plan Selection

Applicant:

☐ B ☐ C ☐ D ☐ E
☐ F ☐ HDF ☐ G ☐ I

Pay Claims to: ☐ Me ☐ My Provider

2nd Applicant: ☐ Same as Applicant or

☐ B ☐ C ☐ D ☐ E
☐ F ☐ HDF ☐ G ☐ I

Pay Claims to: ☐ Me ☐ My Provider

Federal law allows a 6 month open enrollment period to an applicant who is: (1) age 65 or older and first enrolled in Medicare Part B; or (2) now age 65 and previously enrolled in Medicare Part B. *If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.*

Part III – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans (see form "GI-MS-06"). Please include a copy of the notice from your prior insurer with this Application.

PLEASE ANSWER ALL QUESTIONS

Please mark "Yes" or "No" below with an "X" to the best of your knowledge

		Applicant Yes	Applicant No	2nd App. Yes	2nd App. No
1) a)	Did you turn 65 in the last 6 months?	☐	☐	☐	☐
b)	Did you enroll in Medicare Part B in the last 6 months?	☐	☐	☐	☐
c)	If Yes, what is the effective date? ☐☐-☐☐-☐☐☐☐ (mm/dd/yyyy) 2nd App.: ☐☐-☐☐-☐☐☐☐				
2)	Are you covered for Medical Assistance through the state Medicaid program?	☐	☐	☐	☐
	NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer "NO" to this question				
	If "Yes",				
a)	Will Medicaid pay your premiums for this Medicare Supplement policy?	☐	☐	☐	☐
b)	Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium?	☐	☐	☐	☐
3) a)	If you had coverage from any Medicare Plan other than Original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your *"Start"* and *"End"* dates below. If you are still covered under this plan, leave *"End"* blank.				
	Start ☐☐-☐☐-☐☐☐☐ End ☐☐-☐☐-☐☐☐☐ (mm/dd/yyyy)				
b)	If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐	☐	☐
c)	Was this your first time in this type of Medicare Plan?	☐	☐	☐	☐
d)	Did you drop a Medicare Supplement policy to enroll in the Medicare Plan?	☐	☐	☐	☐
4) a)	Do you have another Medicare Supplement policy in force?	☐	☐	☐	☐
b)	If so with which company? _____ What plan do you have? _____				
c)	If so, do you intend to replace your Current Medicare Supplement policy with this policy? (If "Yes" complete replacement notice.)	☐	☐	☐	☐
5)	Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan)	☐	☐	☐	☐
a)	If so, with what company? _____ What kind of policy? _____				
b)	What are your dates of coverage under the other policy? If you are still covered under this plan, leave *"End"* blank.				
	Start ☐☐-☐☐-☐☐☐☐ End ☐☐-☐☐-☐☐☐☐ (mm/dd/yyyy)				

Part IV – Alternate Payor (Protection Against Unintended Lapse)

I understand that an Alternate Payor is a person other than myself who will receive notice of lapse or termination of my insurance policy for nonpayment of premium. My Alternate Payor will not be notified until thirty (30) days after a premium is due and unpaid.

☐ I elect NOT to designate an Alternate Payor.
☐ I elect to designate an Alternate Payor, named below.

Alternate Payor – (First Name - MI - Last Name)

Address

City State Zip

9500000802

Part V – Additional Medical Information

Complete this section for applicants who do not meet guarantee issue requirements as an Open Enrollee or Eligible Person. Please check "Yes" or "No" beside each question, if multiple conditions, please circle the condition that applies. If any answer to questions 1 through 6 is "Yes", a policy will not be issued to the person whom the answer applies. Under Open Enrollment, health questions are not required to be answered.

	Applicant		2nd App.	
	Yes	No	Yes	No
1. During the past TWO YEARS, have You seen a physician, been diagnosed, treated or taken medication for:				
a) Amyotrophic Lateral Sclerosis (ALS), Multiple sclerosis, or Myasthenia Gravis?	☐	☐	☐	☐
b) Organ transplant, Kidney failure, or Cirrhosis of the liver?	☐	☐	☐	☐
c) AIDS or HIV positive?	☐	☐	☐	☐
d) Parkinson's Disease?	☐	☐	☐	☐
e) Systemic Lupus?	☐	☐	☐	☐
f) Alzheimer's disease or dementia?	☐	☐	☐	☐
2. During the past FIVE YEARS, have You seen a physician, been diagnosed, treated or taken medication for:				
a) Leukemia, Internal cancer, Lymphoma, Melanoma, or Hodgkin's disease?	☐	☐	☐	☐
b) Heart Attack, Congestive heart failure, Stroke, Atrial fibrillation?	☐	☐	☐	☐
c) Heart surgery including angioplasty?	☐	☐	☐	☐
d) Amputation?	☐	☐	☐	☐
3. During the past TWO YEARS, have you been:				
a) Hospitalized due to mental illness or received treatment for the use of alcohol or drugs?	☐	☐	☐	☐
b) Confined to a wheelchair or had a condition requiring regular oxygen use?	☐	☐	☐	☐
c) Hospitalized three or more times, been confined to a nursing home or assisted living facility, or received home care?	☐	☐	☐	☐
d) Treated for complications of diabetes such as neuropathy (numbness, tingling or burning in the arms or legs), retinopathy (eye damage), kidney disease or gastroparesis (damage to the stomach nerves)?	☐	☐	☐	☐
4. Do you require supervision or assistance from another person (due to physical or cognitive decline) with activities of daily living such as walking, eating, bathing, dressing, toileting, transferring or taking medications?	☐	☐	☐	☐
5. Has a doctor scheduled or recommended any tests, surgery or workup to rule out disease or to determine the cause of your health concerns that have not been completed?	☐	☐	☐	☐
6. Has your doctor recommended confinement to a nursing home or assisted living facility or recommended home care?	☐	☐	☐	☐
7. Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months?	☐	☐	☐	☐

Part VI – Additional Medical Information (continued)

List ALL prescription medications taken at any time in the past 30 days.
(use additional sheets if necessary)

Applicant	2nd App.	Prescription name	Reason taking	DateLast used (mm/yy)
☐	☐			
☐	☐			
☐	☐			

9500000803

Part VII – Premium Payment & Administration

Payor if not Applicant: ☐ List Bill ☐ Other _____

Name

Address

City State Zip

INITIAL Premium Paid:

$,.

☐ Annual ☐ Semi-Annual

☐ Quarterly ☐ 2 months (for MBD)

Requested Effective Date (if other than Application Date)

-- -- (mm-dd-yyyy)

RENEWAL: ☐ Direct Bill ☐ Bank Draft (Account Type: ☐ Checking ☐ Savings):

Bank Routing # (9 digits): Bank Account # [4 or more (do not include check #)]: Select Draft Date:

Bank Name: _____

Name(s) of Depositor(s): _____

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

Part VIII – General Information

1) You do not need more than one Medicare Supplement policy.

2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare Benefits.

3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy, will be instituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

Part IX – Agreement & Acknowledgement

As part of the Medicare Supplement Application process, Equitable Life & Casualty has certain information that you should review as part of your decision to purchase our policy. Please indicate your receipt of this information:

- ☐ Outline of Coverage
- ☐ Replacement Notice, if applicable
- ☐ Medicare Buyers Guide
- ☐ Notice of Information Practices and Privacy Policy

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinment in prision.

☐ I authorize payment by Bank Draft if selected in Part VII.

Signed at (City and State): ____________________ Date: ☐☐-☐☐-☐☐☐☐

Signed Applicant: ____________________ 2nd Applicant ____________________

Witnessed by Agent: ____________________ Agent Number ____________________

Send policy to: ☐ Applicant ☐ Agent

5

Part X – Agent Supplement

Yes	No	
☐	☐	1. Did you personally interview the applicant(s) and witness any signatures?
☐	☐	2. State the name and relationship of any other person present when this application was taken. Name ____________________ Relationship ____________________
☐	☐	3. Did you review the application for correctness and any omissions?
☐	☐	4. Did the applicant(s) review the application for correctness and any omissions?

Listed below are all other health insurance policies I have (i) sold to the Applicant(s) which are still in force; and (ii) sold to the Applicant(s) in the last 5 years which are no longer in force.

Applicant	2nd App.	Company	Type of Policy	Effective Date	In Force
☐	☐				❒ Yes ❒ No
☐	☐				❒ Yes ❒ No
☐	☐				❒ Yes ❒ No

Agent #1 Signature ____________________ Date __________

Agent #2 Signature ____________________ Date __________

Agent #1 Name (please print) Agent # Split %

Agent #2 Name (please print) Agent # Split %

9500000805

Equitable Life & Casualty Insurance Company
Outline Of Medicare Supplement Coverage - Cover Page: 1 of 2
Benefit Plans A, H, HDJ, J and L

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL Plans

Basic Benefits For Plans A-J: Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services; Blood - First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Faciltiy Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare					Preventive Care NOT Covered by Medicare

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year {$1,900} deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are {$1,900}. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Equitable Life & Casualty Insurance Company
Outline Of Medicare Supplement Coverage - Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A - J, but cost sharing for the basic benefits is at different levels.

J	K**❖	L**
Basic Benefits	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4,440] Out-of-Pocket Annual Limit***	$[$2,220] Out-of-Pocket Annual Limit***

❖ Plans currently not available for sale

** Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

Ultimate Premiums - Annual

	Plan A	Plan H	Plan J	Plan HDJ	Plan L
<65	1,240	1,495	1,650	723	1,050
65	1,240	1,495	1,650	723	1,050
66	1,240	1,495	1,650	723	1,050
67	1,240	1,495	1,650	723	1,050
68	1,240	1,495	1,650	723	1,050
69	1,240	1,495	1,650	723	1,050
70	1,240	1,495	1,650	723	1,050
71	1,240	1,495	1,650	723	1,050
72	1,240	1,495	1,650	723	1,050
73	1,240	1,495	1,650	723	1,050
74	1,240	1,495	1,650	723	1,050
75	1,240	1,495	1,650	723	1,050
76	1,240	1,495	1,650	723	1,050
77	1,240	1,495	1,650	723	1,050
78	1,240	1,495	1,650	723	1,050
79	1,240	1,495	1,650	723	1,050
80	1,240	1,495	1,650	723	1,050
81	1,240	1,495	1,650	723	1,050
82	1,240	1,495	1,650	723	1,050
83	1,240	1,495	1,650	723	1,050
84	1,240	1,495	1,650	723	1,050
85	1,240	1,495	1,650	723	1,050
86	1,240	1,495	1,650	723	1,050
87	1,240	1,495	1,650	723	1,050
88	1,240	1,495	1,650	723	1,050
89	1,240	1,495	1,650	723	1,050
90	1,240	1,495	1,650	723	1,050
91	1,240	1,495	1,650	723	1,050
92	1,240	1,495	1,650	723	1,050
93	1,240	1,495	1,650	723	1,050
94	1,240	1,495	1,650	723	1,050
95	1,240	1,495	1,650	723	1,050
96	1,240	1,495	1,650	723	1,050
97	1,240	1,495	1,650	723	1,050
98	1,240	1,495	1,650	723	1,050
99	1,240	1,495	1,650	723	1,050

Modal Factors: SA = Annual x.520, Q = Annual x.265, MBD= Annual ÷ 12

Standard Premiums - Annual

	Plan A	Plan H	Plan J	Plan HDJ	Plan L
<65	1,860	2,243	2,475	1,085	1,575
65	1,860	2,243	2,475	1,085	1,575
66	1,860	2,243	2,475	1,085	1,575
67	1,860	2,243	2,475	1,085	1,575
68	1,860	2,243	2,475	1,085	1,575
69	1,860	2,243	2,475	1,085	1,575
70	1,860	2,243	2,475	1,085	1,575
71	1,860	2,243	2,475	1,085	1,575
72	1,860	2,243	2,475	1,085	1,575
73	1,860	2,243	2,475	1,085	1,575
74	1,860	2,243	2,475	1,085	1,575
75	1,860	2,243	2,475	1,085	1,575
76	1,860	2,243	2,475	1,085	1,575
77	1,860	2,243	2,475	1,085	1,575
78	1,860	2,243	2,475	1,085	1,575
79	1,860	2,243	2,475	1,085	1,575
80	1,860	2,243	2,475	1,085	1,575
81	1,860	2,243	2,475	1,085	1,575
82	1,860	2,243	2,475	1,085	1,575
83	1,860	2,243	2,475	1,085	1,575
84	1,860	2,243	2,475	1,085	1,575
85	1,860	2,243	2,475	1,085	1,575
86	1,860	2,243	2,475	1,085	1,575
87	1,860	2,243	2,475	1,085	1,575
88	1,860	2,243	2,475	1,085	1,575
89	1,860	2,243	2,475	1,085	1,575
90	1,860	2,243	2,475	1,085	1,575
91	1,860	2,243	2,475	1,085	1,575
92	1,860	2,243	2,475	1,085	1,575
93	1,860	2,243	2,475	1,085	1,575
94	1,860	2,243	2,475	1,085	1,575
95	1,860	2,243	2,475	1,085	1,575
96	1,860	2,243	2,475	1,085	1,575
97	1,860	2,243	2,475	1,085	1,575
98	1,860	2,243	2,475	1,085	1,575
99	1,860	2,243	2,475	1,085	1,575

Modal Factors: SA = Annual x.520, Q = Annual x.265, MBD= Annual ÷ 12

ARKANSAS

Plan B			Plan D			Plan F			Plan I		
Age	MBD	Annual	Age	MBD	Annual	Age	MBD	Annual	Age	MBD	Annual
ALL Ages	261.67	3,140.00	ALL Ages	229.92	2,759.00	ALL Ages	378.92	4,547.00	ALL Ages	231.42	2,777.00

Plan C			Plan E			Plan G			High Deductible Plan F		
Age	MBD	Annual	Age	MBD	Annual	Age	MBD	Annual	Age	MBD	Annual
ALL Ages	319.34	3,832.00	ALL Ages	251.00	3,012.00	ALL Ages	266.17	3,194.00	ALL Ages	170.67	2,048.00

*Modal Factors: SA = Annual *.520, Q = Annual *.265, M = Annual *.09*

For These Plans Use Application Form A-OS-06 AR

Equitable Life & Casualty
INSURANCE COMPANY

3 Triad Center
Salt Lake City, Utah 84180-1200

PREMIUM INFORMATION

We, Equitable Life & Casualty Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. Each year following the changes in Medicare's deductibles and/or benefits your rates may be adjusted at that time. Your initial premiums are guaranteed for one full year.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at: P.O. Box 2460, Salt Lake City, UT 84110-2460. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither Equitable Life & Casualty nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	$0	[$1024] (Part A deductible)
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	$0	Up to [$128] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

***Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B			
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	$0	Up to [$128] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

***Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 [$135] (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 [$135] (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B Deductible) $0

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan C (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip out-side the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

*** Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%]	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual charges to $40 a visit.	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	$0	$1600	Balance
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:	All but [$512] a day	[$512] a day	$0
-While using 60 lifetime reserve days			
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

*** Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 [$135] (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B Deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT — NOT COVERED BY MEDICARE** Some annual physical and preventive tests administered or ordered by your doctor when not covered by Medicare -First $120 each calendar year -Additional charges	 $0 $0	 $120 $0	 $0 All costs

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

** **This high deductible plan pays the same as Plan F after one has paid a calendar year [$1,900] deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

HIGH DEDUCTIBLE PLAN F
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

**** *Once you have been billed [$135] of Medicare-Approved amounts for covered services, (which are noted with four asterisks), your Part B Deductible will have been met for the calendar year.*

** **This high deductible plan pays the same as Plan F after one has paid a calendar year [$1,900] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$,1900] DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
-First [$135] of Medicare Approved Amounts****	$0	[$135] (Part B Deductible)	$0
-Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts****	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

**** *Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with four asterisks), your Part B Deductible will have been met for the calendar year.*

** **This high deductible plan pays the same as Plan F after one has paid a calendar year [$1,900] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

Part A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment First [$135] of Medicare Approved Amounts****	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA -First $250 each calendar year -Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:	All but [$512] a day	[$512] a day	$0
-While using 60 lifetime reserve days			
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

** *Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 [$135] (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B Deductible) $0
AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan -Benefit for each visit -Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit) -Calendar Year Maximum	 $0 $0 $0	 Actual charges to $40 a visit. Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance Balance Balance
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

*** Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 [$135] (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B Deductible) $0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% up to lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

*** Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	$0	$1,600	Balance
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	$0	Balance

MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

** *Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts **	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

SERVICES (Medicare Part B, cont'd)	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts**	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	$0	$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
****PREVENTIVE MEDICAL CARE BENEFIT — NOT COVERED BY MEDICARE:** Some annual physical and preventive tests administered or ordered by your doctor when not covered by Medicare			
-First $120 each calendar year	$0	$120	$0
-Additional charges	$0	$0	All costs

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

** **This high deductible plan pays the same as Plan J after one has paid a calendar year [$1,900] deductible. Benefits from High Deductible Plan J will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$1024] (Part A deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN J
MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR

**** *Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with four asterisks), your Part B Deductible will have been met for the calendar year.*

** **This high deductible plan pays the same as Plan J after one has paid a calendar year [$1,900] deductible. Benefits from High Deductible Plan J will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	 $0 Generally 80%	 [$135] (Part B Deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All Costs [$135] (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 [$135] (Part B deductible) 20%	 $0 $0 $0

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE (continued) AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	$0	$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
*****PREVENTIVE MEDICAL CARE BENEFIT — NOT COVERED BY MEDICARE** Annual physical and preventive tests ordered by your doctor when not covered by Medicare			
-First $120 each calendar year	$0	$120	$0
-Additional charges	$0	$0	All costs

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

* *You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,220 each calendar year. The amounts that count toward your out-of-pocket limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-Approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item of service.*

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

** A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1024]	[$768] (75% Part A deductible)	[$256] (25% Part A deductible)◆
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to $93 a day	Up to $31 a day◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%◆
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	Generally, most Medicare eligible expenses for out-patient drugs and inpa-tient respite care.	75% of coinsurance or copayments	25% of coinsurance or copayments◆

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with four asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [$135] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	$0 Generally 75% or more of Medicare-Approved amounts Generally 80%	$0 Remainder of Medicare-Approved amounts Generally 15%	[$135] (Part B deductible)◆ All costs above Medicare-Approved amounts Generally 5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward the annual out-of-pocket limit of $2,220*)
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts**** Remainder of Medicare-Approved Amounts	$0 $0 Generally 80%	75% $0 Generally 15%	25%◆ [$135] (Part B Deductible◆) Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* ***This plan limits your annual out-of-pocket payments for Medicare-Approved amounts to $2,220 per year.*** However, this limit does NOT include charges from your provider that exceed Medicare-Approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item of service.

PARTS A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 15%	$0 [$135] (Part B Deductible)◆ 5%◆

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

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